MEDICARE MEDICAID 20th

The First Two Decades 1965 1985

Department of Health & Human Services

Health Care Financing Administration

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INTRODUCTION

This booklet has been prepared as a background document for the news media, and collects some of the major events of Medicare and Medicaid history from the past 20 years in narrative form.

Although we hope it will be useful to journalists preparing articles and TV pieces marking the anniversary of Medicare and Medicaid, the booklet should also be a helpful reference for putting future stories on health care financing into broad perspective.

Questions about the information in this booklet should be addressed to the Office of Public Affairs of the Health Care Financing Administration, 6325 Security Boulevard, Baltimore, Maryland 21207, or by calling the Agency's Press Office directly on (202) 245-6145 in Washington, D.C.

Office of Public Affairs
Health Care Financing Administration

MEDICARE
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Administrator's Statement

Twenty years ago on July 30 a new law was enacted to help meet the basic health care needs of millions of elderly Americans and those too poor to pay for health care. We know those programs today as Medicare and Medicaid, the largest and most successful government health effort the country has ever undertaken. These programs have grown steadily over the past twenty years. They have been improved to cover new medical procedures and services that are more effective and more efficient than was possible two decades ago. The chronically disabled are now covered by Medicare. The program now helps pay for kidney dialysis, for hospice care, home health care and outpatient surgery as well as hospital and physician services. Medicare beneficiaries are now able to join health maintenance organizations as well as competitive health plans. Medicaid pays for basic and mandatory health care services for the needy in all states and for a long list of optional services that States may provide, with Federal support, at their own initiative. Medicare and Medicaid together serve more than 50 million Americans in their 20th anniversary year at a cost of $95 billion.

These programs have grown dramatically in another way as well. In its first year of operation Medicare expenditures amounted to a little over $1 billion. This year those expenditures will amount to $71 billion or about $8 1/2 million per hour. This growth has come about as Medicare opened coverage to new groups, as the number of elderly Americans has grown, and as the price of health care rose dramatically. But this year, I'm happy to report that the cost of these programs is finally being brought under control.

We have adopted a way of reimbursing hospitals for the services they provide that encourages them to be efficient and watchful with your tax dollars in the same way they are watchful of your good health. As we enter our third decade of Medicare, the trust funds that support it are adequate to meet immediate future needs, and provide sufficient lead time to take the necessary steps to ensure that Medicare benefits future generations as well. That's a legacy of which this Administration can be proud and which the public has every right to expect. I'm delighted to wish Medicare and Medicaid and all its millions of beneficiaries a happy 20th anniversary and offer a pledge of continued service from those programs in the years to come.

Carolyne K Davis

Carolyne K. Davis, Ph.D.
Administrator
Health Care Financing
Administration

1965 -- Medicare Enacted

Friday, July 30 was a dry, hot day in Independence, Missouri. Lyndon Baines Johnson, second tallest President of the United States, towered over a beaming predecessor, Harry S Truman, during a ceremonial signing of the Medicare Bill at the Truman Library in Harry Truman's hometown.

In fixing his signature to the Health Insurance for the Aged Act, the Medicare portion of the Social Security Amendments of 1965, President Johnson became the first in a long line of Presidents who have signed Medicare legislation into law. Every President since 1965 has enacted changes and improvements in Medicare that have swelled the program into the largest health effort ever undertaken in this country.

But nearly 20 years before Johnson's historic signing, Harry Truman first proposed Medicare as a Federal health insurance program under Social Security. He did so in a special message to the Congress on November 19, 1945.

"The people of the United States love and voted for Harry Truman," President Johnson later said, "not because he gave them hell, but because he gave them hope."

At the 1965 signing the feisty former President and one-time artillery battery commander, haberdasher, county judge, U. S. Senator and Vice President was for once at a loss for words.

"I am glad to have lived this long to the signing of the

Medicare Bill today," said the 81-year-old Truman. "I thank you most highly for coming here, it's an honor I haven't had done to me -- well, quite a while, I'll say that to you."

Praising the newborn program, President Johnson said, "No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that have so carefully been put away over a lifetime so that they might enjoy dignity in their later years."

Medicare was to go into effect on July 1, 1966.

Action on the Medicare Bill had been completed in the Senate just two days before the signing in Independence. It followed nearly 25 years of often bitter debate between organized medicine and Medicare's proponents.

In its beginning, Medicare was an expansion of the Social Security program enacted in 1935, near the depth of the Great Depression. The Medicare Program promised from its start hospital care, nursing home care, home nursing services and outpatient diagnostic service for Americans 65 years of age and older.

The original Medicare Bill also contained provisions for insurance to cover doctor bills of older Americans and certain other medical expenses. That part of Medicare was, and still is, voluntary. Participants in the beginning agreed to pay $3 per month in premiums.

Some Medicare founders foresaw funding the program through successive step increases in Social Security payroll taxes over a 22-year period. The original legislation did not specify how

hospitals and doctors would be paid. The then U.S. Department of Health, Education and Welfare did, however, anticipate contracting out to Blue Cross, Blue Shield and other health insurance carriers what were to become mammoth Federal bill paying chores -- exceeded in 1985 only by the Defense budget and Social Security itself.

Medicare was scheduled to serve approximately 19 million older Americans at its outset. Today there are more than 30 million beneficiaries.

In Chicago, Dr. F.J.L. Blasingame, executive vice president of the American Medical Association, said of the AMA's long opposition to Medicare as President Johnson was signing the bill, "We were fighting a legislative battle, as was our right. Now that it's become law, it's up to the individual physician to decide (whether to participate)."

AMA representatives had met with the President in Washington on the day before the signing of the Medicare Bill. Dr. Blasingame now expected to meet with HEW Secretary Anthony J. Celebrezze about Medicare rules and regulations in the near future.

Back in Independence, the same President who was beginning to command wars both on poverty and in Vietnam used 22 pens to sign the Medicare Bill. The first pen went to Harry Truman, the second to his wife Bess.

1965 -- Medicaid: Almost An Afterthought.

All but ignored in the widely covered Medicare debate of 1965 was Medicaid, the joint Federal-State medical assistance program that sought to help the poor.

Dr. Carolyne K. Davis, Administrator of the Government's Health Care Financing Administration, just this year described Medicaid as "almost an afterthought" in the Social Security Amendments of 1965 which contained both Medicare and Medicaid legislation.

So obscure was Medicaid that it received not a single mention in the hundreds of words The New York Times used to cover the signing of the Medicare legislation on the day following -- July 31, 1965.

Medicaid probably came about upon the realization by lawmakers and staff that Medicare did not cover care for the indigent elderly or chronically disadvantaged -- people too poor to pay even the modest deductibles or "down payments" Medicare legislation required of its beneficiaries, although Medicare paid the bulk of hospital payments and doctor bills patients incurred.

From its beginning, Medicare has been a Federal program, now run by the Health Care Financing Administration, a component of the U.S. Department of Health and Human Services -- formerly the Department of Health, Education, and Welfare.

Medicaid, in contrast, has since its inception been financed jointly by the Federal Government, State Governments, the U.S. Flag

Territories and the District of Columbia.

From the beginning, States, Territories and the District have designed and managed their own Medicaid programs through state welfare offices, public health offices, social service offices, or state Medicaid offices. In some areas local tax funds contribute to Medicaid.

As early as 1935 proposals were made by the Roosevelt Administration to include health insurance for the elderly in the Social Security Program. The Social Security Act of 1935 did not, however, include health insurance for the poor or legions of Depression-effected unemployed.

"Medical services," according to Dr. Davis, "were but a small part of welfare assistance until the Kerr Mills Act of 1960." That Act provided to the States Federal matching aid for medical payments made to the poor or "the medically needy" -- largely elderly people confronted with medical expenses too great for middle income families to cope with.

"But many saw Kerr-Mills only as a stopgap to the problem," Dr. Davis said, and "senior citizens wanted to know why they should have to retire and accept 'welfare' to receive health services.

"Medicaid has been the answer," she continued. "It's been estimated, at one time or another, one out of every five Americans has received care through Medicaid.

"And for millions of aging and disabled, a bed has been available in a licensed nursing home when they needed one -- and it may be said that Medicaid spawned today's nursing home industry.

"And countless children of the poor have had disabling

conditions diagnosed and treated through Medicaid immunization programs and EPSDT, Medicaid's Early Periodic Screening, Diagnosis and Treatment program for children," the Health Care Financing Administration's Administrator said.

Medicare and Medicaid split the notion of welfare from health care for the aged. The elderly were now able to pay for health care through the health insurance program of Medicare. At the same time, the needy -- whether elderly or not -- could be aided by the medical assistance program of Medicaid.

Conceived as a near-afterthought, Medicaid has provided a quality of life and a level of health to millions of Americans whose option otherwise would have been going without proper medical care.

1965 - 1966 -- Start-Up and Apprehension.

Three months after the Medicare Bill was enacted, John W. Gardner, Secretary of Health, Education and Welfare, told the first White House Conference on Health that there had been "a great move forward in recent health legislation."

He described the achievements of the 89th Congress, which included Medicare and Medicaid, as "A series of promissory notes... that 'you and I must honor.'"

Debate prior to passage of the Medicare Bill focused almost entirely upon whether the advent of Medicare would be the beginning of Government controlled medicine, and the beginning of the end of a privately operated health care system in America.

Now, with that issue set aside if not settled, and Medicare about to come to be, most attention focused upon the effects Medicare would put upon already rising demands for health care services in the United States.

Two days after the Medicare Bill had been signed, Dr. Howard A. Rusk wrote in the New York Times:

> "When Medicare becomes effective on July 1, 1966, this steady increase (in demand for health services) will be greatly increased.
>
> "At that time 19 million Americans, 65 years of age and older, will become eligible for hospital and nursing care under Social Security.

"The additional need comes at a time when the states report that 150,000, or one out of five of our existing hospital beds are obsolete and should be replaced."

Health services communicators pointed to the pressures Medicare would place on nursing homes, already in short supply, and in many areas, substandard.

On August 23 -- three weeks after signing the Medicare Bill -- President Johnson, worried about Medicare's effects on medical costs, assigned H.E.W. Secretary Gardner to begin a "major study" of rapidly rising medical charges.

Secretary Gardner told reporters after his White House meeting with the President that "I am not saying there are abuses, but we want to take a very quick look at it. We will move rapidly."

The President may have ordered the investigation as a result of rumors that some doctors were raising fees by more than 300 percent for elderly patients in anticipation of Medicare's operational beginning on July 1, 1966. Hospital costs were known to be rising steadily as the end of 1985 drew near.

In the spring of 1966 there were approximately 10,000 hospitals in the United States. Excluding children's hospitals and others that did not treat elderly people, about 7,200 hospitals could qualify for Medicare certification.

Throughout that spring H.E.W. and other agencies were trying hard to sell Medicare's nondiscrimination requirements to hospitals in the South.

For the first time, too, Medicare would require the vast majority of American hospitals to be checked for compliance with Government-set medical standards.

Hospital administrators, however, did not worry about red tape in the admission of Medicare patients. "The paper work being required by the Medicare Act is not any greater than that required by Blue Cross," said I. Leon Goodman, executive director of the Federation of American Hospitals, two weeks before Medicare was to become operational.

Speaking from the East Room of the White House on June 16, President Johnson said, "In a little more than a fortnight, for the first time in the history of America, every senior citizen will be able to receive hospital care -- not as a ward of the state, not as a charity patient, but as an insured patient."

The President concluded his remarks on the ever increasing concern for the cost of the Medicare Program about to be:

> "We must be concerned with the higher prices for hospital medical service, or a lot of the good we have done will be undone. So we ask the responsible medical societies and professional leaders to take the lead in trying to help us prevent unreasonable costs for health services. And the best prevention is intelligent self-restraint by doctors and hospital officials."

By June 25, 6,204 of the 7,200 hospitals eligible had applied for Medicare certification. Of these, 4,743 had received certification and signed on as Medicare hospitals.

Before Medicare's opening day, 85 percent of eligible hospitals were either on board or had applied. Percentages were, however, considerably smaller in some southern states, due to refusal to comply with Medicare's nondiscrimination requirement.

Medicare became operational on Friday, July 1, on schedule. By then 92 percent of the nation's hospital beds were either within the program or about to be.

"Since I signed the historic Medicare Act last summer," President Johnson said, "we have made more extensive preparation to launch this program than for any other peaceful undertaking in our nation's history."

Much of the credit for the start-up went to Arthur Emil Hess, 50-year-old director of the Bureau of Health Insurance of the Social Security Administration, who had been in charge of Medicare's development since before passage of the bill. His mother and father, Swiss immigrants, were on that first day both eligible for and supporters of Medicare. Ironically, Hess himself was overdue for a gall bladder operation. He was not yet covered by Medicare. It would be 1983 before Federal employees would pay into the program.

1967 - 1973 -- The Beginning Years

There were many fears before the beginning of Medicare's first full year about problems this mammoth and bold new venture in medical services would pose.

> Would America's hospitals be swamped with an invasion of elderly Medicare patients?
>
> Would refusal of physicians to participate spell an early death to Medicare itself?
>
> Would there be sufficient compliance with civil rights requirements to make enough beds available to Medicare patients in some parts of the country?
>
> What effect would the increased medical services demand caused by Medicare have upon doctor bills?

By early 1967 some of the fears at Medicare's outset were found to be groundless. Hospital hallways were not packed with an overflow of Medicare patients.

Many doctors still weren't exactly happy with Medicare, but neither did they go on strike against it in large numbers.

Civil rights compliance problems remained in some hospitals, but not enough to cause anything like a national stir.

In mid-1967 Commissioner George M. Ball of the Social Security Administration reported that older Americans had received 15 percent more in-patient hospital service during the first 11 months of Medicare than they would have had, had the program not

come to be.

Commissioner Ball said Medicare's civil rights compliance requirements opened many hospital doors previously closed to minorities. In some areas, "Minority group members now have access to high quality medical care for the first time," he declared.

Dorothy P. Rice, Chief of the Social Security Administration's Health Insurance Research Board, delivered the first detailed statistical analysis of Medicare's initial year. Speaking before an American Public Health Association meeting in Miami Beach, she reported that the average Medicare patient's hospital stay during the program's first year was 19 days. There were five million admissions of four million Medicare patients. Per capita payments averaged $175 for every person enrolled in Medicare during the first year. Of those who were hospitalized, about one in 12 went on to nursing home care after hospital discharge.

Altogether there were 19.5 million Medicare enrollees at the end of the first full year, or 9.7 percent of the U.S. population at the time.

At the end of the first full year, Medicare's hospital deductible, the amount Medicare enrollees themselves paid for hospitalization, was $40. This was equal to the average hospital cost for one day of room and board in 1967.

Costs Begin To Climb

As early as the day after Medicare began in 1966 there were widely circulated rumors about doctors raising their prices in anticipation of the huge new program. Smart moneymakers in medicine, according to the rumors, were hiking prices to establish higher fees as "customary" and "reasonable" to future Medicare auditors.

By the fall of 1968 there was a wide variety of estimates as to how much medical care costs had increased since the passage of the Medicare Bill in 1965. The Tax Foundation estimated medical costs had doubled in three years.

> "To date, the major demonstrable effect of the 1965 Federal legislation creating Medicare has been a shift in financing medical care from the private to the public sector," the Foundation's report contended.

Near the close of the Johnson Administration, on the last day of 1968, outgoing HEW Secretary Wilbur J. Cohen had doctor bills on his mind at a news conference he had called:

> "Unless physicians exercise unusual restraint," he said, "I can only believe that Congress will do something they (doctors) do not like."

Reporters present speculated Secretary Cohen was suggesting

that unless doctors began to police rising fees themselves, Congress would one day set physician fees for specific services performed for Medicare patients.

Spiralling medical costs became serious concerns of state governments as well as at the Federal level. Governor Ronald Reagan of California in January, 1967 proposed instituting statewide "the concept of prepaid health insurance for the indigent." At the same time he asked the California legislature to make any fraud by a vendor against the state's health programs a crime.

In early 1969 HEW reported that public and private health costs in 1967, pushed along by Medicare and Medicaid, topped $50 billion.

This was an overall increase of about 12 percent over the total amount spent for health services in 1966. But as a result of Medicare and Medicaid, Government spending in 1969 increased by 41 percent, coming to a total of $17.8 billion, according to the Social Security Bulletin.

Abuse and Crackdown

President Richard M. Nixon delivered the following message to the Congress of the United States outlining the health goals of his Administration on February 3, 1970:

"In the Sixties, the Federal Government embarked on a number of new health care programs. Medicare currently covers hospital costs and physicians services for 20 million aged. Medicaid provides coverage for over 10 million poor.

"Serious problems remain. Foremost among them are the rapid rise in medical care prices, inadequate health services for the poor, and other health problems only recently recognized.

"To cope with fast-rising demand and health costs, we need to increase the efficiency and supply of our medical resources -- both physical and human. We must provide more practicing physicians, dentists, nurses and other health manpower. I have proposed revisions in the Hill-Burton program to increase construction of facilities for outpatient care as a means of easing pressure on hospitalization or inpatient treatment facilities... Revisions also will be proposed in Medicaid to stimulate the use of proper, but less expensive medical treatment outside hospitals and long terms care institutions..."

The President's concern for still rapidly rising medical costs was echoed a few days later, on February 9, when newspapers across the country reported a Senate Medicare study revealing widespread abuses and recommending a limit on doctors' fees charged to Medicare.

The study, conducted by the Senate Finance Committee, was a year long effort. It was the first to suggest setting specific schedules for Medicare and Medicaid doctor fee payments.

For some medical services the Senate study found doctors charging Medicare patients up to four times more than they were billing Blue Shield, New York Life and other health insurers for identical physician services.

"Since Medicare went into effect four years ago," The New York Times reported, "its costs have about doubled, and those of Medicaid have quadrupled. For the fiscal year that ends June 30, Medicare will cost the Government about $8 billion and Medicaid $5 billion.

"Part of the increase is due to inflation, yet medical care costs are rising at twice the rate of the increase in the cost of living."

A news source close to the Senate Finance Committee was quoted as saying, "Congress was willing to pay a price at the start of Medicare to solicit the cooperation of doctors, many of whom then violently opposed it, in order to get going...but some congressmen now think its time to tighten the language of the act to hold down doctors' fees and reduce costs."

The Senate study found some physicians, albeit a small number, raking in outlandish amounts from Medicare and Medicaid in the beginning years of the two programs. Top dubious honors went to a New York state doctor who billed Medicare and Medicaid $1,419,116.

By February 25, 1970 the Nixon Administration was formally proposing caps on Medicare and Medicaid doctor fees for given services.

John G. Veneman, HEW Under Secretary, told the Senate Finance Committee that the Administration would much prefer to negotiate a

fee structure with physicians, but failing that, the Government would be prepared to impose a fee structure upon doctors serving Medicare and Medicaid patients if needs be.

Under Secretary Veneman later reported that the American Hospital Association, which had supported Medicare from its beginning, now backed the Administration's stand to structure Medicare hospital and doctor charges, placing limits on both.

Dr. Gerald D. Dorman, president of the American Medical Association, was in sharp dissent:

> "Physicians are disturbed by threads of additional Federal controls," he said. "Burdening these busy doctors with more red tape and restricting payments to unrealistically low levels may drive them away from participating in Medicare and Medicaid. Then the Government will have discriminated against many people who need medical care."

By the spring of 1970 Chairman Wilbur D. Mills of the House Ways and Means Committee was proposing a 20 point plan to "plug loopholes" in Medicare and Medicaid financing, giving HEW wide authority over hospital and doctors' fees.

Former HEW Secretary Cohen's farewell warning to doctors now appeared to be coming true.

Cost factors finally led to crackdowns on certain practices. One of those most common early abuses was the use of Medicare for custodial rather than the required convalescent care in nursing homes. Social Security Commissioner Ball ordered enforcing rules in earnest against the practices in 1971, as well against financial excesses.

On April 7, 1973 Dr. William I. Bauer, a 48 year old internist from Greeley, Colorado, was named head of a new office of Professional Standards and Review in the Department of Health, Education and Welfare. A year earlier a physician peer review program had been enacted to ensure the appropriate quality and utilization of medical services for Medicare and Medicaid.

During Medicare's first seven years Hawaii became the first state to provide a prepaid Medicaid plan for welfare families. Hawaii contracted with the Kaiser Foundation Health Plan. Families that signed up received complete prepaid medical services, except for dental care.

Medicaid Costs Unpredictable

During its opening years, Medicaid costs were both exceedingly high, and highly unpredictable.

Predicting Medicaid costs was difficult because of wide variations in state program requirements for Medicaid eligibility. By the summer of 1967, 33 states had Medicaid programs, each drawn to it's own specifications.

In New York a family of four with one wage earner was eligible for Medicaid help to pay doctor and hospital bills if the family's annual income was less than $6,000.

Across the country in California, the same family's annual income had to be less than $3,900 to qualify for Medicaid.

The Federal Government paid 50 to 83 percent of Medicaid costs. Federal payment percentages were determined by average incomes in the several states, which in turn paid the remaining Medicaid costs.

On March 1, 1968 President Johnson sent a supplemental appropriation request to the Congress asking for more money to continue operating Medicaid. The request was for $568 million -- about 50 percent more than the Administration had estimated earlier for Medicaid in all of 1968.

In a rare understatement, President Johnson allowed, "That was a pretty wide error in budget estimating."

By December, 1968 the Federal Government's share of Medicaid's cost was being estimated at $2.6 billion for the fiscal year then ending on June 30. That was $1 billion more than the Administration had forecast.

Among revisions President Nixon recommended for the Johnson Administration budget he inherited was a reduction by $267 million in Federal Medicaid contributions. As it would with Medicare, the Nixon Administration recommended Medicaid pay schedules for doctors be keyed to existing private insurance pay schedules for given medical services. Dentists were included, since Medicaid covered dental services as well.

New York State cut nearly 200,000 low income people from the nation's most expensive Medicaid program in 1968. Welfare recipients were not cut, but the move reflected increasing public awareness of funds not going to the truly needy for whom the program was intended.

Robert H. Finch, the Nixon Administration's first Secretary of Health, Education and Welfare, placed blame publicly on American medicine for a large part of Medicaid's skyrocketing costs.

Senator Ribicoff, a Democrat, in a bipartisan role wrote to Secretary Finch on "the need for genuine physician participation in controlling the cost" of Medicare.

Secretary Finch wrote back, "I am coming to believe that a major factor is the degree physicians are involved in the Medicaid program, not simply as purveyors of medical care, but also as watchdogs of costs and guardians of quality."

There were reports at the time that doctors in some areas were hospitalizing Medicaid patients unnecessarily for tonsilectomies and other minor surgery. Secretary Finch told Senator Ribicoff that HEW was asking for 150 new slots to hire Federal investigators to strengthen Medicaid supervision.

During his term as HEW Secretary, Finch did not succeed in obtaining defined schedules for either Medicare or Medicaid doctor payments. But before leaving office, he had on record HEW regulations calling for identifying and preventing fraud against Medicaid.

Children on Medicaid

On July 1, 1969 a little known program came to be that has been of enormous importance to the health care of poor children and young adults.

EPSDT stands for Early and Periodic Screening, Diagnosis and Treatment. Federal legislation authorizing EPSDT requires the Medicaid agencies of the states, U.S. Territories and the District of Columbia to provide early and periodic medical screening, diagnosis and treatment for eligible poor children and young adults under 21.

Medicaid agencies now must inform all AFDC welfare families of EPSDT's availability to poor children. Medicaid agencies are required to arrange to provide medical diagnosis and care for poor children.

EPSDT diagnosis and treatment programs find and correct medical problems before they result in permanent disabilities. EPSDT immunization programs protect poor children against measles, polio, whooping cough, diptheria, small pox and other diseases.

Eyeglasses, hearing aids and dental care are paid for by EPSDT. Heart and kidney diseases, tuberculosis, ear, eye, nose and throat disorders; sickle cell anemia, parasites, lead poisoning and drug abuse are among disorders for which poor children and young adults are treated every day.

If needed, EPSDT treatment is paid for up to certain limits set by the states for their Medicaid agencies.

Expanding Eligibility

From the very beginning of Medicare and Medicaid it was known that significant numbers of people in need of medical services would not be eligible to receive them through either of the national programs. Some were very old -- people whose working days ended before they worked long enough under Social Security to qualify as Social Security beneficiaries.

Others were blind or severely disabled people who were receiving Social Security assistance, but were not 65 years old, which Medicare required its enrollees to be.

President Johnson called attention to this deficiency in a special message he sent to the Congress on aid to the elderly in late January, 1967:

> "Medicare is an unqualified success," the President wrote. "Nevertheless, there are improvements that can be made and shortcomings which need prompt attention.
>
> "The 1.5 million seriously disabled Americans under 65 who receive Social Security and railroad retirement benefits should be included in Medicare. The typical member of this group is over 50. He finds himself in much the same plight as the elderly. He is dependent on Social Security to support himself and his family. He is plagued by high medical expenses and poor insurance protection.

> "I recommend that Medicare be extended to the 1.5 million disabled Americans under 65 now covered by Social Security and railroad retirement systems."

But it was not until March 21, 1972 that Medicare began on its road to expansion, at first only for paying customers. The Senate Finance Committee voted to permit persons over 65 years old without Social Security coverage to enroll in Medicare if they could pay the full insurance costs.

A barely reported Associated Press dispatch said the cost of Medicare hospital insurance would be $31 a month for new Medicare enrollees who pay their own way.

It was estimated that 400,000 persons would be eligible to buy coverage. Most were aliens; or former Federal, state and local government employees; and retired domestics.

The Senate committee bill stipulated that, to enroll, these new people would have to join Medicare Part B, that part of Medicare covering doctor bills. This would cost $5.60 per month, which the Government would match.

Another move to cover large numbers of people ineligible for but in need of Medicare occurred in late October, 1972, when a weary Senate and House negotiating team shelved a Nixon Administration welfare reform program but approved new Administration-supported benefits under Medicare for the aged, blind and disabled.

The Senate and House negotiators voted to extend Medicare coverage to 1.7 million blind and seriously disabled people who

were receiving Social Security benefits, but who were not 65 years old.

President Nixon signed a Social Security bill containing the expansion of Medicare to previously ineligible aged, blind and disabled people on October 30, 1972.

The President called the bill "landmark legislation that will end many old inequities and will provide a new uniform system to well-earned benefits for older Americans, the blind and the disabled."

The bill also resolved a modern doctor's dilemma in favor of patients like Shep Glazer, one of about 10,000 persons whose lives depended on a cumbersome and expensive therapy.

Shep Glazer appeared before the House Ways and Means Committee in the fall of 1971. With him was a large gadget, about the size of a commercial washing machine, to which he was attached by two tubes hooked up to one of his arms.

It was a kidney dialysis machine and it kept him alive. Without it he and other sufferers of acute kidney disease would die of poisoning from waste materials their systems could not eliminate.

When Shep Glazer testified before Ways and Means there were an estimated 10,000 Americans paying between $12,000 and $25,000 a year for treatment on artificial kidney machines. On behalf of his fellow patients, Glazer asked for Medicare benefits to pay for the treatment.

The dilemma was a financial one. As more kidney disease patients would be kept alive, the cost of the assistance would grow

into hundreds of millions and even billions of dollars, it was correctly predicted.

Congress and the President sided with the patients. The committee included an End Stage Renal Dialysis (ESRD) program in the bill signed by President Nixon the following year expanding Medicare eligibility.

Under ESRD, Americans with acute kidney disorders requiring expensive dialysis treatment would be covered by Medicare, whatever their ages happened to be.

Some people further argued at the time that victims of all catastrophic illnesses -- cancer, heart disease, epilepsy and other dreaded ailments -- should also have been given Medicare protection against the immense medical expenses they incur.

Medicare and the Health Industry

Making money on Medicare was on the minds of many from the beginning. Well before Medicare went into actual operation during the summer of 1966, Wall Street health industry analysts pondered this potentially huge billion dollar industry, and how its pie would be cut.

Some securities analysts were predicting bonanzas for drug manufacturers and hospital supply companies. American Hospital Supply Corporation, Johnson & Johnson, and Becton, Dickensen were frequently mentioned as stocks with growth potential with the arrival of Medicare and Medicaid.

Many on Wall Street foresaw surefire profits in Medicare for Eastman Kodak and its X-ray film, and for Simmons in mattresses and hospital beds. Baxter Laboratories, Merck and A.H. Robbins were all trading at their highs four days before Medicare and Medicaid went into operation.

Health insurers were pessimistic at first about Medicare. They correctly anticipated that Medicare would clearly become the primary health insurer for middle class Americans 65 and older.

During Medicare's first year private insurers did indeed lose an estimated $500 million in premium payments. But at the same time, they gained a whole new market. They soon began to offer "supplementary" protection to the 19 million Medicare enrollees.

The supplementary policies covered for the most part Medicare's deductibles, or the relatively small amounts Medicare enrollees had to pay themselves as patient shares of hospital and doctor bills. Some supplemental policies also covered full or partial payments for hospital stays longer than those allowed by Medicare.

By the end of Medicare's first year of operation, most private insurers felt they had better risk patterns and profits after Medicare than before it, when health claims against their companies by the elderly were frequently large.

1974 to 1980 -- Medicare, An American Institution.

Medicare's 10th Anniversary was quietly observed on July 30, 1975, with Wilbur J. Cohen, as dean of the School of Education at the University of Michigan, calling Medicare a "breakthrough" and crediting it with breaking "the back of its ideological opposition to the public role in health insurance."

It was Cohen who drafted the first health insurance legislation that President Truman proposed unsuccessfully in 1952. But some recalled that Government-sponsored health insurance was talked about as early as 1912 in a reelection campaign by Theodore Roosevelt, which he lost.

By 1974 Medicare had become an institution to 21.8 million elderly and 3 million disabled Americans. While some in power still spoke grandly about wider national health programs to replace Medicare, Medicare itself was in place.

On Medicare's 10th anniversary, an estimated 95 percent of Medicare Part A hospitalization enrollees were also voluntarily enrolled in Medicare Part B, the part that covers doctor bills.

While Medicare, and particularly Medicaid, had critics both inside and outside the medical community at the end of their first decade, passions had indeed quieted. The programs were here to stay.

Criticism, now nearly all rational in tone, was often directed at Medicare and Medicaid costs. Equally frequent was criticism that Medicare and Medicaid were inflating the cost of hospital

care. The consumer price index showed average daily cost for a hospital room up 138 percent, and still rising, since the advent of Medicare.

Unwieldy and separate organizational structures were also cited with reference to Medicare and Medicaid. Senator Herman E. Talmadge, chairman of the Health Subcommittee of the Senate Finance Committee, had oversight authority for Medicare and Medicaid. He was proposing a new department, or a new agency within HEW, to be responsible for administering both Medicare and Medicaid and the enormous Federal health care financing these programs entailed.

Price Control

On February 7, 1974 the Nixon Administration recommended that the anti-inflation wage and price control program of the previous two-and-a-half years be ended, except for health care and petroleum products.

John T. Dunlop, director of the Cost of Living Council, said the Congress should keep controls on health until such a time as a national health insurance program which the Administration would propose was enacted.

Dunlop told the Congress that before the wage-and-price controls had been put into effect, there had been extraordinary inflationary pressure placed upon health care as a result of the infusion of new Federal monies through Medicare and Medicaid.

Dr. James A. Scammon, Chairman of the AMA's Board of Trustees, disagreed. He said to keep controls on health and hospital costs would be "capricious and unwise."

Dr. Scammon prevailed.

In August, Gerald R. Ford entered the White House in what was to be a brief but severe economic crisis. Health insurance was in the background, but debate continued between proponents of widely expanded national health insurance programs.

The national health insurance debate at the time pitted a Kennedy-Mills bill versus a program involving the private sector favored by the previous Nixon Administration. By 1979 President Jimmy Carter was advocating a plan under which any American family with hospital and medical costs of more than $2,500 per year would be paid any additional charges by a mandatory employer-employee health insurance program. About $20 billion in Federal money would be used to pay all health care costs of the poor, the aged and the disabled. Medicare and Medicaid would be merged into the Federally funded program.

Stuart Eizenstat, President Carter's chief advisor for domestic affairs, predicted that no national health plan covering every American would work without federal controls on the costs of all health care providers.

"You can't have all those additional demands on the system without some sort of controls," Mr. Eizenstat contended.

The issue seemed to have been decisively settled in 1980 by the electorate. Medicare and Medicaid would be as far as America

would go in the way of public medical care for the foreseeable future.

Enter HCFA

New systems were put in place for both Medicare and Medicaid by the Carter Administration in March, 1977.

In an attempt to "simplify and streamline" his department, then the largest in the Government, HEW Secretary Joseph A. Califano, Jr. placed Medicare under a new agency called the Health Care Financing Administration (HCFA).

Before the new agency was created, Medicare was operated by the Social Security Administration, the largest single component of HEW. Medicare came under Social and Rehabilitation Services, another HEW arm.

HCFA began with a $32 billion budget and policy responsibility for Medicare, while the Social Security Administration continued to manage Medicare applications and payments in the field through its myriad of local SSA offices across the nation.

Similarly, HCFA held policy responsibility for Medicaid, but local management and administration of the program remained with the states.

Medicaid Reforms

As Medicare became institutionalized among older middle class Americans, Medicaid revealed a need for reform that became apparent by 1974.

In their book, Welfare Medicine in America, Robert and Rosemary Stevens noted in the early Seventies that Medicaid was loosely conceived "in the climate of social injustice and poverty eradication of the mid-1960's, when many Americans thought of their government as sort of a super Ford Foundation, whose seemingly inexhaustible resources would move us all perceptibly closer to Utopia."

Nobody in the beginning seemed to have the remotest idea of what Medicaid would cost, according to the authors. "Congress had projected the additional cost of the new program at $238 million annually." When Welfare Medicine in America appeared, the yearly cost of Medicaid had already climbed to $15 billion in only eight years.

Looking back nearly a decade later, the Stevenses credited Medicaid with having done enormous amounts of good. Millions of poor Americans received effective medical care that they would not have had without Medicaid. The authors even suggested some poor receive more and better care through Medicaid than do some middle class people through Medicare, where patients share parts of the cost.

But is was clear to many students of Medicaid's first decade that the good Medicaid accomplished early on came at unexpectedly great cost; and that it was too often accompanied by waste, fraud and abuse perpetrated by ruthless exploiters of the poor.

The Carter Administration's Department of Health, Education and Welfare took the first concrete steps to screen out ineligible Medicaid beneficiaries on March 16, 1975.

An HEW press release carried in a short Associated Press bulletin estimated that ineligible receivers of Medicare could be costing state and Federal taxpayers as much as $600 million per year.

"The chief obstacles to determining eligibility now," HEW said, "are lack of verification of a patient's financial resources, automatic renewal of eligibility without checking, and billing for Medicaid services when eligibilty has never been determined."

A few days later HEW proposed regulations in the Federal Register that would order states to examine small statistical samples of their Medicaid recipients "to determine the rate of ineligibility and the amount of money misspent."

Earlier in the same month the Government had brought suit against a group of doctors, chiropractors and Medicaid clinic operators in New York City. The suit was for $625,000 for false claims against Medicaid.

During Medicare's first ten years in New York State, Medicaid costs actually overtook the costs of the state's public assistance program.

But as late as February, 1975, New York State's $3 billion-a-year Medicaid program operated without a computer. One costly result was the ease with which Medicaid-mill operators "ping-ponged" Medical clients from hospital to hospital with no way of immediate record verification.

New Medicaid systems were put in place in New York and elsewhere, but only after staggering costs and irreparable damage to Medicaid's reputation during the first ten years.

Senator Kennedy even suggested Medicaid change its name.

Medigaps and Beneficiary Costs

While hospital suppliers, drug manufacturers, nursing homes, proprietary hospitals and other health related industries continued to benefit from the infusion of Federal funds through Medicare and Medicaid, few profited more for the good of all than did private sector health insurance companies.

By 1975 Medicare's own budget had climbed to more than $15 billion. Even so, more than half of Medicare's 20 million-plus enrollees had private insurance of their own to supplement Medicare. By 1976 their expenditures for private health insurance were estimated at well over a billion dollars per year.

Dr. Gladys Ellenbogen, an economist and consultant to the Senate Special Committee on Aging, said in the spring of 1975 that "Private insurance fills a need, since Medicare was not designed to be a program covering all health costs of the elderly.

"Unless Medicare is substantially expanded, private policies will continue to be important sources of protection," she continued.

There were then, and still are, three basic gaps in Medicare that millions of Medicare enrollees use private insurance to cover:

> The first is the dollar amount for the deductibles that patients themselves must pay before Medicare payments begin. These amounts had risen steadily for hospitalization (Part A) benefits -- from $40 in 1966, for example, to $92 in 1975 ($400 today).

The next gap is what the patient must pay for hospitalization between the 61st and 90th day. This was $10 per day in 1966, $23 per day ten years later ($100 today).

Finally, under Part B medical services, Medicare generally paid 80 percent of "reasonable charges" in the 1970's. Patients paid the remaining 20 percent of their doctor bills. There is also a Part B deductible, currently at $75.

From Medicare's outset private insurance competed vigorously to cover these gaps in Medicare with affordable protection. Some private policies also covered out-of-hospital prescription drugs, hearing aids, the first three pints of blood each year, and other health care services and supplies not included in Medicare.

There were, however, some abuses in the sale of private insurance during Medicare's first ten years. Perhaps the most common was the unscrupulous selling of overinsurance to elderly Medicare recipients, and the replacement of one policy with another by the same agent for the sake of a second costly commission.

The Senate Special Committee on Aging's Dr. Ellenbogen said "Age 65 is not a magic age at which one is likely to become suddenly expert on the technicalities of insurance policies."

The Health Insurance Institute added in 1975 that a person is best advised to consider supplementary private insurance plans before his or her 64th birthday.

Program Costs Increase

Spiralling costs were of continuing concern to Medicare watchers on Capitol Hill and elsewhere during the program's middle years.

In the fall of 1974, HEW set a new policy called "utilization review" to "police doctors." The program called for an immediate review of patients by nurses and technicians when the patients entered a hospital.

If the nurses and technicians questioned the need for a hospital stay, a group of doctors would review the case and make a decision before the end of the second day.

Caspar W. Weinberger, then HEW Secretary, said "it is anticipated that the new regulations will save millions of dollars a year by eliminating unnecessary hospitalization and unneeded services and procedures."

Between 1974 and 1980 dozens of efforts were made at as many levels to curb health costs by policing the purveyors of health services and supplies.

But during the same period, thoughtful observers of Medicare, Madicaid and rising health costs were looking at these costs in another way: from the standpoint of consumer demand.

One such observer was medical writer Richard D. Lyons. Writing in The New York Times in April, 1977 -- a time when 10 percent of the federal budget went to health care -- Mr. Lyons made the

following observation:

> "Hospitals are labor-intensive, high technology operations whose huge outlays are usually paid for by public and private insurers, such as Medicare and Medicaid and the Blue Cross and Blue Shield plans, rather than from the pockets of individual patients. Such indirect payment breeds a lack of cost consciousness by the doctors who order hospital services and the patients who receive them.
>
> "Also, patients want the best. The open hospital ward is something out of another generation, and private and semiprivate rooms are the norm.
>
> "The modern hospital in some respects is like a hotel, with some rooms containing television sets, radios and telephones. Hospitals of Spartan comfort meet with consumer resistance, and this in turn leads to the building of new facilities. The result is an excess of 100,000 hospital beds nationally at an annual cost of $6 billion."

True, Medicare and Medicaid do not pay for radio and television and telephones in hospitals. But some observers in the Seventies were beginning to see that quality of service is a factor sometimes overlooked in continuing debates about health care costs.

1981 - 1985 -- Tightening Cost Controls.

By its 15th year of operation, during the summer of 1981, Medicare had become the Federal Government's largest single benefits program. Celebrations were muted, however.

There was deep concern about Medicare's cost on both sides of the Congressional aisle. House and Senate committees were threatening to cut at least $1 billion from the Reagan Administration's Medicare requests for fiscal 1982.

The Congressional Budget Office was prescribing bitter medicine to the medical community. Congress' budget arm was saying hospital and doctor costs had to be brought under control if Medicare was to survive and serve a growing aging population.

By the spring of 1983 the nation decided it could no longer afford the traditional cost-plus type of hospital billing for its Medicare patients. Hospital costs had climbed at a rate of 12.6 percent in 1982. This increase was three times the general rate of inflation for that year.

On April 22 President Reagan signed into law the 1983 Social Security Amendments containing the Administration's Prospective Payment System, the new method for paying hospitals for providing care to Medicare's nearly 30 million enrollees.

The Administration predicted correctly that Prospective Payment would have a profound impact on hospital and medical economics. Efficient hospitals would be rewarded. The inefficient ones would have to change to survive.

The old cost-based system of hospital billing provided no incentive to control cost. In fact, as many Medicare observers pointed out, the traditional system encouraged overspending on the part of hospitals, with much of the costs passed through to Medicare and private health insurers. The cost-based payment system had hospitals increasing revenues by raising costs, often unobserved, and with Medicare or private insurers most often paying the bills.

The Prospective Payment System, on the other hand, is based on pre-set rates for specific diagnosis-related groups.

The groups take into account patient diagnosis, patient age and sex, treatment procedure, and discharge status. Regional and urban and rural locations and also taken into account in the rate ultimately paid.

Under the Prospective Payment System an efficient hospital capable of delivering health care services for Medicare patients at costs below pre-set rates gets to keep the savings. Less efficient hospitals that go over pre-set Medicare rates for given services are losers.

With prospective payment phasing into effect beginning on October 1, 1983, new incentives came to the hospital industry. The motive now was to find areas where savings could be made in order

to avoid losses.

New Jersey, New York, Maryland and Massachusetts were given waivers freeing them from the new prospective payment program. These states had hospital cost control programs already in place. New Jersey's plan was used in part as a model for HCFA's Federal plan.

Margaret M. Heckler, Secretary of Health and Human Services, said in a statement issued with the new rules, "Prospective Payment for hospitals is the most important improvement in the history of the Medicare program. It corrects a fundamental flaw in Medicare's current system, which almost by rote has paid hospitals their costs. With prospective payment, for the first time Medicare will reward the hospitals which improve performance. Efficiency will now bring dollar dividends to those institutions."

Echoing Secretary Heckler, Robert Pear wrote on the front page of The New York Times that "The new system represents the biggest change in Medicare since the health insurance program for the elderly was created in 1965."

Reaction among hospital people, who had always supported Medicare, was for the most part favorable. Commenting on the new prospective payment program, R. Allen Vaughan, director of financial services for the Arizona Hospital Association, said:

> "Hospitals are now looking at themselves as factories producing product lines. In the past the system discouraged hospitals from holding down costs. Now they are faced with the same type of marketplace incentive as many other businesses have always faced."

When prospective payment went into place, Medicare accounted for 30 percent of all hospital placements and 36 percent of hospital revenues. Medicare patients, because of age and frequent multiple ailments, tended to stay in hospitals longer -- over ten days, opposed to a national average of 7.6 days for all hospital patients.

By July 9, 1984 HHS Secretary Heckler could tell the annual meeting of the National Association of Counties in Seattle that "The rate of inflation in medical care costs has been cut almost in half, from 10.8 percent in 1981, to 6.3 percent."

Data made available earlier in the same week by the American Hospital Association backed the secretary's statement. J. Alexander McMahon, then president of the association, credited the Medicare prospective payment policy in part for the reduction.

Mrs. Heckler told the National Association of Counties meeting that the "efficient behavior" affected by prospective payment in hospitals was "spilling over into the general hospital population and is not limited just to Medicare patients."

Commenting again on The New York Times' front page on August 26, 1984, Robert Pear wrote:

> "A new Medicare payment system has profoundly altered the way hospitals do business, making them more efficient and cost conscious, apparently without damaging the quality of health care.
>
> "After nearly a year of experience with the new system, hopital officials around the country say the average length

of stay for both elderly and younger patients has declined dramatically..."

With the prospective payment plan in operation less than a year, the Health Care Financing Administration said in August that the average hospital stay for Medicare patients was now down to 7.5 days, a 20 percent reduction from the year before.

Speaking for the American Association of Retired Persons, Jack E. Christy said, "We like the concept so well we think it ought to apply to everybody. We have not gotten a lot of complaints about hospitals skimping on services..."

By Medicare's 20th birthday several private health insurance companies were developing their own prospective payment plans to reduce hospital costs for everybody they insured. The idea may indeed apply to nearly everybody in the not too distant future.

While the prospective payment system is clearly an improvement, it is by no means flawless. On July 3, 1985, The New England Journal of Medicine published results of a study showing that while Medicare's prospective payment system clearly identified 468 disease categories for purposes of setting hospital rates, the system makes no provision for varying intensities of severe illnesses.

Susan Horn, who directed the study, used heart attacks as an example. Under the prospective payment system a hospital treating a patient with a relatively mild heart attack would be paid the same amount as another hospital caring for a Medicare patient with a severe heart attack requiring a longer hospital stay, round the

clock nursing care and other added services.

Robert J. Rubin, a former Assistant Secretary of the Department of Health and Human Services and an architect of the prospective payment system, said, "The absence of a severity index was always understood to be a serious flaw" in the hospital payment plan. But referring to Ms. Horn's study, he said further, "At present there is no severity measure that is administratively simple and inexpensive, including hers."

Peer Review Organizations

As early as 1972 legislation had been on the books establishing Peer Standards Review Organizations (PSROs) to monitor Medicare hospital practices. PSROs were often local medical societies.

Now called Peer Review Organizations (PROs) and operating under more specific Federal requirements, they are now a condition of doing business for hospitals treating Medicare patients. As of October 1, 1984, hospitals had to have a PRO under contract to review quality of care and master admissions in order for the hospital to be paid for services under Medicare.

The PROs review diagnoses, quality of hospital care provided to Medicare patients, the appropriateness of admissions and discharges, and the nature and handling of unusual cases involving Medicare patients.

Doctors Find Cost Cutting Hard

The very special and respected entrepreneurial position of the physician in American life had been a tradition few people ever questioned. But after the Congress passed a 15-month freeze on Medicare doctor bills during the summer of 1984, Dr. Gilbert R. Clark of Waterloo, Iowa saw things changing. He was quoted as follows in The New York Times Sunday Magazine on July 1:

> "If you ask most doctors why they became medical doctors back in the 40s and 50s, it was not money," he said. "It was a way of life and a thing they wanted to do. They wanted to take care of people. Now suddenly everybody else is in their offices -- the insurance companies, the third party people, telling them how to run it..."

Not the least of the health insurance organizations was the country's largest, Medicare. As the Government sought to put hospital costs in perspective, so too did the Administration put a leash on doctor bills.

From its very beginning Medicare had a formula to determine how doctors would be paid under its Part B medical insurance program. The actual claims from doctors were, and still are, to be made by the "carrier," a private insurance company under contract to Medicare that covers all or parts of a state, the U.S. Territories and the District of Columbia. Among Medicare carriers

are Blue Cross and Blue Shield, Aetna Life and Casualty, Equitable, The Prudential and other national and statewide health insurance firms.

A doctor's payments for Medicare services are not based solely on his or her current charges for the service or sevices performed. They are based instead on what the law defines as "reasonable charges," which in turn are approved and determined by the Medicare carrier.

The carriers decide what a doctor will be paid for a given service by identifying the lowest cost of three possibilities. One is the customary charge for the same service in the given area, based on statewide reviews the carriers are required to make each year.

Another alternative is the prevailing charge, which is the amount high enough to cover the customary charge in three out of four bills during the previous year.

A third choice is the doctor's actual bill. The charge approved by the carrier will be the lowest of the customary, prevailing, or actual charge. Medicare will pay its share -- 80 percent of the approved charge.

Doctor payment formulas similar to the one above have been in force throughout Medicare's two decades. The patient must apply for the Medicare payment in the above example. Some doctors accept Medicare assignment, a payment method in which Medicare pays the doctor directly. The doctor must agree to accept the approved charge as the full charge for the service.

Where the physician does not take Medicare assignment, Medicare pays the patient 80 percent of the approved charge, and it is the patient's responsibility to pay the full doctor bill.

Doctors have always been free to accept assignment for individual patients in all cases, only for some patients, or for only some cases. But since 1984, Medicare has encouraged doctors to become "participating physicians," signing an agreement to accept assignment in all cases.

Physicians may choose to become "participating" for competetive reasons, particularly in geographic areas with large numbers of Medicare beneficiaries. But a major reason has also been "the freeze."

Until recently the main drawback in the payment procedure was the inability to control spiralling doctor charges for nearly two decades. By freely raising their own charges, the doctors also increased "customary" and "prevailing" rates in their areas, and with them, Medicare costs.

In 1984 the House and Senate finally passed a freeze on doctors' Medicare fees.

Federal Judge Sarah Evans Barker refused an injunction sought by the AMA and she allowed an extension until October 15, when the 15-month freeze on Medicare doctor fees went into effect.

There was an exception. "Participating" physicians would get an annual increase in the prevailing charge, based on inflation, enabling them to receive higher payments from Medicare.

While some AMA leaders denounced the Medicare fee curb with

bitterness reminiscent of earlier Medicare battles, by January 24, 1985 press coverage of the dispute was low key and back paged by editors for the most part.

Spencer Rich, reporting in The Washington Post on physician acceptance of the freeze, wrote:

> "Doctors accepted government-set fees and gave up the right to bill patients for anything beyond the government-set maximum in a record 66 percent of Medicare cases in November...
>
> "The big jump over the previous level of 56 percent in fiscal 1984 was due largely to the fact that 29.8 percent of doctors serving Medicare patients agreed under a new provision of the law to accept the government-set payments as full payments for their Medicare patients. The remaining doctors accepted it in some cases but did not agree to do so all the time."

Physicians accepting assignment and becoming "participating" doctors can save Medicare and elderly Americans hundreds of millions of dollars, according to HCFA administrators and Medicare experts elsewhere.

At the same time, acceptance of the "approved" fees by two-thirds of the Medicare cases will discourage other doctors from raising their fees. Competitive forces are now in place to keep Medicare doctor fees from skyrocketing again.

Doctors can still charge their Medicare patients more than the

Government-set fees allow for services. These doctors must, however, collect the entire payments from their patients themselves. Their patients, in turn, receive only four-fifths of the Government-approved rate from Medicare.

Medicare and HMOs

During the spring of 1984 the Department of Health and Human Services published regulations giving nearly 30 million Medicare enrollees the right to join and assign their Medicare benefits to Health Maintenance Organizations.

HHS Secretary Heckler described the new option as a "historic step," giving Medicare enrollees who chose HMOs more complete medical coverage with lower out-of-pocket costs."

HMOs had been in operation for nearly 50 years when they became available as an option for Medicare enrollees. There were nearly 300 HMOs in operation in 1984. They had nearly 8 million members, with about 200,000 Medicare enrollees added within a year of the option's becoming available to them.

The Health Care Financing Administration encourages Medicare enrollees to consider the HMO option. From HCFA's standpoint, HMOs are both good providers of complete medical care, and they are their own insurance companies. As such, their costs are kept as low as possible, and their emphasis is on preventative medicine.

Medicare directly pays the HMO monthly for Medicare enrollees

using the Health Maintenance Organization option. Enrollees pay the HMO a monthly premium which covers the cost of Medicare deductibles and coinsurance for which the enrollee would be responsible.

Why sign up? Jane Bryant Quinn of Universal Press Syndicate answered this way in her column earlier this year:

> "Sign up because a Medicare HMO can save you money and perhaps provide better health care than you had before.
>
> "Normally, Medicare doesn't cover all medical bills. You pay a deductible and a portion of each bill that is above the Medicare limit. Many older people find these costs to be substantial (averaging $2,000 per year). To protect themselves, they buy 'Medigap' health insurance policies not included in Medicare.
>
> "With a Medicare HMO, you don't need Medigap insurance. The HMO covers everything, with no deductible. There is usually a monthly membership fee ranging from $5 to $45 (the average is $15 to $20 a month), but there are few or no additional out-of-pocket expenses. One HMO charges no fees. An HMO may provide services not normally covered by Medicare, such as eye-glasses, prescription drugs and routine physical exams. So the Medicare HMO offers more for your money."

Ms. Quinn offers two cautions: First, once a person has signed up with an HMO, he or she cannot go back to a former doctor or specialist of personal choice and expect Medicare to pay the bill.

She warns in addition, "If you want to quit the HMO, you cannot do so right away. You have to give notice, and then keep on visiting the HMO until Medicare officially takes you off its rolls. On paper, disenrollment is supposed to take about a month, but it's often two months or longer. If you go to another doctor before the paperwork is completed, Medicare won't pay..."

Individual hospitals, under pressure from prospective payment and eager to keep beds occupied for maximum efficiency, are contracting with HMOs as the sole hospital facility for the HMO patient. Hospital and HMO administrators both claim economies result from the arrangement that benefit Medicare and non-Medicare HMO members as well as the hospital.

Medicare Heads Home

In the autumn of 1981 the plight of a 3-year-old girl taught the nation that its multi-billion dollar Medicare and Medicaid programs were in need of re-thinking.

Her name was Katie Beckett, of Cedar Rapids, Iowa, hospitalized with complications from viral encephalitis, an inflamation of the brain.

On November 10 President Reagan told a news conference how the girl, a Medicaid patient, had spent most of her life hospitalized more by government regulation than by medical need, illustrating

that Federal rules "can be a tremendous expense to the taxpayer," and at the same time, "do no good to the patient."

Katie's doctors and her parents wanted her to be cared for at home, the President said. Home care would cost about $1,000 a month. Yet rigid and well spelled out Medicaid regulations required that Katie be cared for in a hospital if she was to be eligible for Medicaid to pay for her care.

Medicaid would pay $6,000 per month for her hospital care, but not $1,000 a month for care at home because her parent's income disqualified them for Medicaid assistance outside a hospital.

Following the President's news conference, the Department of Health and Human Services gave Katie a waiver to leave the hospital without losing the less costly Medicaid payment for care at home.

It was a milestone for a long Medicare and Medicaid trip toward home.

Actually, thoughts about bringing Federal health insurance benefits into homes had been around for some time. In the spring of 1978, during the Carter Administration, Rep. Millicent H. Fenwick of New Jersey offered a plan to then HEW Secretary Califano that would in effect have authorized Federal stipends or cash payments to elderly people eligible for Medicare or Medicaid who wanted to stay home and out of hospitals or nursing homes.

Secretary Califano ordered a HCFA study, saying "I'm personally committed to finding workable alternatives to institutionalization." Since then several changes have been bringing Medicare and Medicaid services home.

Hospice

Spencer Rich reported on one development in The Washington Post on August 28, 1982:

> "Contained in the fine print of the 1982 tax bill is what might be considered the perfect piece of legislation: a provision that promises to cut federal spending, promote a humanitarian service and provide comfort for thousands of terminally ill people.
>
> "Sponsored by more than half of the Senate and two-thirds of the House, the provision for the first time will permit Medicare funding the hospice movement, which believes that those who are dying are better off in the loving atmosphere of their homes than they are in hospitals."

Hospice care has become visible in the United States only in the past decade. In this country hospice services are home oriented rather than occurring in institutions, as they tend to be in Great Britain where the modern hospice movement began in the 1960s.

The Medicare legislation authorizing hospice care will expire in 1986 if congressional review of the program does not suggest its renewal. Meanwhile, the Health Care Financing Administration can use Medicare hospital insurance to help pay hospice care if these three conditions are met:

1. A doctor must certify that the patient is terminally ill.
2. A patient must choose to receive hospice care rather than the standard Medicare benefits for the terminally ill.
3. The care must be provided by a Medicare-certified hospice program.

Most patients receiving hospice care in the United States are terminally ill cancer patients. There numbers are estimated at about 12,000. About 200,000 Medicare enrollees die of cancer every year. How many will elect to use hospice care remains to be seen, but it has been estimated they could number well over 100,000 by the turn of the century when hospice benefits are more widely known and better understood.

Medicare Home Health Care

Medicare now can pay for certain part-time skilled health care in a Medicare enrollee's home for treatment of an illness or an injury.

Medicare can make payments for home health visits only if all four of these conditions are met: (1) The care needed includes part-time skilled nursing care, physical therapy or speech therapy; (2) The patient covered by Medicare is confined to his or her home; (3) A doctor has determined a need for home health care and has set up a home health care plan; and (4) The home health care agency providing services is participating in Medicare.

When all four provisions are met, either Medicare hospital insurance or Medicare medical insurance can pay for an unlimited number of home health visits. Medicare can also pay for occupational therapy when there is no longer need for skilled nursing care at home or other types of therapy.

Medicare can also provide part-time services of home health aides; medical social services; medical supplies; and durable medical equipment, up to 80 percent of the approved charge.

Medicare does not cover general household services, meal preparation, shopping, assistance in bathing or dressing, or other home care services furnished mainly to assist people in meeting personal, family, or domestic needs.

A family member at home still must provide for the personal needs of the patient who elects to take allowable Medicare benefits at home.

Home and Community Based Medicaid Services

Nursing home care, or more specifically, long term institutional care services, account for more than 40 percent of State and Federal Medicaid expenditures, almost $814 billion in 1983.

Appearing before the House Subcommittee on Health and Environment on June 25, 1985, Dr. Carolyne K. Davis, Administrator of the Health Care Financing Administration, commented in detail on Medicaid's Home and Community Based Waiver Program.

"It has been estimated by some," Dr. Davis said, "that a quarter of the current nursing home population might be better served in the community. Many elderly, disabled and chronically ill persons live in institutions not solely for medical reasons, but because of lack of affordable health and social services available to them in their homes or communities, due to the individual's inability to pay for these services or the failure of the State (Medicaid) plan to cover them when they do exist."

HCFA's Administrator called attention to an amendment to the Social Security Act authorizing the Secretary of Health and Human Services to waive certain Medicaid rules in order to allow states to cover through Medicaid "a broad array of home and community based services."

Dr. Davis pointed to the fact that current Medicaid law eliminates the possibility of "Catch 22" type situations wherein parents' income could keep a child unnecessarily hospitalized. "This means that children such as Katie Becket, who are ready to go home, whose parents obviously want them at home, can now live at home and still be covered by Medicaid.

"The opportunities that these waivers afford are enormous," the Administrator continued. "We have heard today the personal experiences of frail or disabled persons whose lives have been enriched by this program. I have personally visited the homes of persons who, but for Home and Community Based Services, would be in an institution. I know the satisfaction these services can bring..."

State management and cost effectiveness to the Medicaid Home and Community Based Services Program are carefully monitored by the Department of Health and Human Services through HCFA. Dr. Davis concluded her remarks to the House subcommittee by saying, "We are hopeful" said Dr. Davis, "that we have designed a program which can offer the welcomed flexibility to provide home and community-based services under Medicaid within statutorily-imposed cost constraints."

Medicaid, too, has been coming home.

Afterword

20 Years of Medicare and Medicaid

The anecdotes and developments chronicled in the previous pages describe just the most recent chapters in America's concern for the health of its citizens. That life, liberty and the pursuit of happiness are among the inalienable rights with which every person has been endowed, is an American credo that dates from the founding of the nation itself. And life and health cannot easily be disentwined as part of the basic concerns of true humanity.

The health of our population -- whether measured by infant mortality among the poor, the dignity and care afforded our elderly, or the achievements of modern medical technology -- is surely one measure of freedom.

Five Presidents have served since Medicare and Medicaid were set up 20 years ago to help elderly Americans, the disabled and the needy obtain health care in a way that is consistent with the values and institutions of a free democratic society. Each of those Presidents has signed legislation improving and altering those programs to better serve the public purpose.

In a letter to the Senate earlier this year from Senator John Heinz, chairman, and Senator John Glenn, ranking minority member, on the Senate Special Committee on Aging, Congressional endorsement of those efforts and of Medicare's achievements is evident.

"This marks the 20th anniversary of the Medicare program," the letter began. "Since its enactment, Medicare has contributed immeasurably to the health and well-being of millions of aged and disabled Americans by helping to ensure access to appropriate and affordable health care.

"... we will introduce a resolution, the sense of the Congress, that Medicare be commended on its 20th anniversary for the program's success in protecting older Americans against the staggering costs of acute health care. This resolution recognizes and salutes the important contribution of Medicare to our nation's health and well-being, and demonstrates our firm commitment to maintaining the integrity of the program.

"Today, more than 28 million older persons and three million disabled persons enjoy insurance protection under Medicare, making it the single largest personal health care financing program in the United States. Hundreds of thousands of physicians and more than 20,000 hospitals, nursing homes, home health agencies, labs and clinics participate in Medicare. Clearly, Medicare is one of the most vitally important and successful programs in the history of our nation. Without it millions of older Americans could not afford even the most basic health care services..."

More than 20 Senators have co-sponsored the resolution.

If the achievements of Medicare and Medicaid have been great, they have also been at great cost, and our latest struggles in public health, as we have seen, are no longer limited to medical science but extend to medical economics.

To keep Medicare and Medicaid working will require bringing runaway health costs under control. To some extent, that turnaround has begun. Medicare and Medicaid dollars can now buy more services than would have been possible if new efficiencies and practices had not been introduced into these programs during the past few years.

While there are still problems remaining in financing the nation's health care, the Health Care Financing Administration remains committed to improvement and service through Medicare and Medicaid in a manner that's fiscally responsible and that ensures the survival of these programs for generations to come.

Office of Public Affairs
Health Care Financing Administration

Note: The Health Care Financing Administration is grateful to the National Press Club Library for staff assistance and the free use of its facilities to conduct research used to produce this Medicare/Medicaid reference.

SELECTED STATISTICS

MEDICARE AND MEDICAID EXPENDITURES
(Millions of dollars)

Year	Total Medicare	Medicare Part A	Medicare Part B	Total Medicaid	Medicaid Federal Portion	Medicaid State Portion
1985*	$70,000	$47,900	$22,100	NA	$23,000	NA
1984*	60,900	41,500	19,500*	$38,651	20,887	$17,764
1983	58,861	39,877	18,984	35,697	19,348	16,349
1982	52,371	36,144	16,227	32,868	17,977	14,891
1981	44,754	30,726	14,028	30,474	17,255	13,218
1980	36,822	25,577	11,245	26,466	14,452	12,014
1979	30,338	21,073	9,265	22,867	13,028	9,839
1978	25,933	18,178	7,755	19,812	11,161	8,651
1977	22,524	16,019	6,505	17,721	10,044	7,677
1976	19,301	13,679	5,622	15,836	9,010	6,826
1975	16,316	11,581	4,735	14,153	7,937	6,216
1974	13,100	9,372	3,728	11,287	6,398	4,889
1973	10,133	7,289	2,844	9,676	5,462	4,214
1972	9,117	6,503	2,614	8,541	4,637	3,904
1971	8,277	5,900	2,377	7,076	3,841	3,235
1970	7,493	5,281	2,212	5,471	3,001	2,470
1969	6,918	4,857	2,061	4,556	2,409	2,148
1968	5,979	4,277	1,702	3,950	1,979	1,971
1967	4,737	3,430	1,307	2,982	1,469	1,513
1966	1,152	949	203	1,512	734	778

* Estimates

Selected Statistics

Year	Medicare Beneficiaries	Medicaid Recipients
1966	19.1 million	Not Avail.
1967	19.5	Not Avail.
1968	19.8	11.5 million
1969	20.0	12.1
1970	20.4	14.5
1971	20.7	18.0
1972	21.1	17.6
1973	23.3	19.6
1974	23.9	21.1
1975	24.6	22.2
1976	25.3	22.9
1977	26.0	22.9
1978	26.8	22.2
1979	27.5	21.5
1980	28.1	21.6
1981	28.6	22.0
1982	29.1	21.6
1983	29.6	21.6
1984(est.)	30.2	22.0
1985(est.)	30.8	22.5

Medicare Reference Chart
1966—1985

Part A—Hospital Insurance
Deductible and Coinsurance Amounts[1]

FOR BENEFIT PERIODS BEGINNING IN	INPATIENT HOSPITAL[2]			SKILLED NURSING FACILITY	HOME HEALTH AGENCY	Blood
	FIRST 60 DAYS	61ST THRU 90TH DAY	60 LIFETIME RESERVE DAYS (NON RENEWABLE)	21ST THRU 100TH DAY	UNLIMITED VISITS[3]	
	DEDUCTIBLE	COINSURANCE PER DAY	COINSURANCE PER DAY	COINSURANCE PER DAY	NO DEDUCTIBLE OR COINSURANCE	DEDUCTIBLE FIRST 3 PINTS
		Always equal to 1/4 of inpatient hospital deductible	*Always equal to 1/2 of inpatient hospital deductible*	*Always equal to 1/8 of inpatient hospital deductible*		*(or equivalent units of packed red blood cells) in a benefit period*
1966	$ 40	$10	Not Covered	Not Covered		
1967	40	10	Not Covered	$ 5 00		
1968	40	10	$ 20	5 00		
1969	44	11	22	5 50		
1970	52	13	26	6 50		
1971	60	15	30	7 50		
1972	68	17	34	8 50		
1973	72	18	36	9 00		
1974	84	21	42	10 50		
1975	92	23	46	11 50		
1976	104	26	52	13 00		
1977	124	31	62	15 50		
1978	144	36	72	18 00		
1979	160	40	80	20 00		
1980	180	45	90	22 50		
1981	204	51	102	25 50		
1982	260	65	130	32 50		
1983	**304**	**76**	**152**	**38 00**		
1984	**356**	**89**	**178**	**44 50**		
1985	**400**	**100**	**200**	**50.00**		

HI Premiums

Effective[4]	7/73	7/74	7/75	7/76	7/77	7/78	7/79	7/80	7/81	7/82	7/83	1/84	1/85
Basic Rate	$33	$36	$40	$45	$54	$63	$69	$78	$89	$113	$113	$155	$174
Basic Premium Increased by 10% For Each 12 Months of Nonenrollment													

1 For services furnished on or after January 1, 1982, the coinsurance amounts are based on the inpatient hospital deductible for the year in which the services were furnished

For services furnished prior to January 1, 1982, the coinsurance amounts are based on the inpatient hospital deductible applicable for the year in which the individual's benefit period began

2 For care in psychiatric hospital—190 day lifetime limit

3 Prior to July 1, 1981, benefits were limited to 100 visits per benefit period under Part A and 100 visits per calendar year under Part B

4 Not applicable prior to 7/73

Department of
Health and Human Services
Health Care Financing Administration
Office of Public Affairs
HCFA Pub. No. 20048-85

Part B—Supplementary Medical Insurance (SMI)

Deductible, Coinsurance and Payments

General Payment Rule for SMI Benefits:
$75 annual deductible effective January 1, 1982, ($60 from 1973 through 1981, $50 from 1966 through 1972) and 80% of approved charges. No payments for first 3 pints of whole blood or units of packed red blood cells in a calendar year (blood deductible). Following are exceptions to this rule:

Home Health Services

- From 1/1/73 through 6/30/82: $60 annual deductible
  100% of reasonable costs
- On or after 7/1/82: No deductible
  100% of reasonable costs

Provider Services and Services of Rural Health Clinics

- Annual deductible
- Reasonable costs
- Less the coinsurance amounts charged

NOTE 1. Outpatient Physician Services for Mental Illness—
50% of approved charges
Up to a maximum of $250 in benefits per year

2. Physical Therapy Services furnished by Physical Therapists in Private Practice—
Maximum annual approved charges
7/1/73 through 12/31/81 $80 per year
1/1/82 and thereafter $400 per year

Initial Enrollment Period

(7 months)

E-3	E-2	E-1	E	E+1	E+2	E+3	E+4	E+5	E+6
X	X	X	C						
			X	C					
				X		C			
					X			C	
						X			C

X—Month of Enrollment
C—First Month of Coverage
E—First Month of Eligibility (ordinarily month individual attains age 65 or 25th month after an individual is entitled to disability benefits)

NOTE Eligible persons will be automatically enrolled for SMI when they first become entitled to HI

General Enrollment Period—Opportunities for enrollment or re-enrollment in SMI, are available from January 1 to March 31 of each year, with coverage effective the following July 1.

Exception. For the period 4/1/81—9/30/81 only, individuals were allowed to enroll in SMI with coverage effective 3 months later.

SMI Premiums

Effective	7/66	4/68	7/70	7/71	7/72	8/73	9/73	7/74	7/76	7/77	7/78	7/79	7/80	7/81	7/82	7/83	1/84	1/85
Basic Rate	$3.00	$4.00	$5.30	$5.60	$5.80	$6.10	$6.30	$6.70	$7.20	$7.70	$8.20	$8.70	$9.60	$11.00	$12.20	$12.20	$14.60	$15.50

Basic Premium will be Increased by 10% For Each 12 Months of Non-enrollment

Time Limit For Filing Part B Claims

Services Received	Claims Must Be Filed By
07/1/66-09/30/66	1968 (April 1)
10/1/66-09/30/67	12/31/68
10/1/67-09/30/68	12/31/69
10/1/68-09/30/69	12/31/70
10/1/69-09/30/70	12/31/71
10/1/70-09/30/71	12/31/72
10/1/71-09/30/72	12/31/73
10/1/72-09/30/73	12/31/74
10/1/73-09/30/74	12/31/75
10/1/74-09/30/75	12/31/76
10/1/75-09/30/76	12/31/77
10/1/76-09/30/77	12/31/78
10/1/77-09/30/78	12/31/79
10/1/78-09/30/79	12/31/80
10/1/79-09/30/80	12/31/81
10/1/80-09/30/81	12/31/82
10/1/81-09/30/82	12/31/83
10/1/82-09/30/83	12/31/84
10/1/83-09/30/84	12/31/85
10/1/84-09/30/85	12/31/86